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ABSTRACT

Designed for state administrative officials, the report examines legal issues involved in treatment and deinstitutionalization of mentally ill and mentally retarded persons. A historical account reviews definitions and available services for the two populations. Implications of significant court decisions are analyzed for cases involving right to treatment, right to least restrictive alternative, right to education, right to liberty, and rights of hospitalized patients in institutions. The issue of deinstitutionalization is considered, and successful approaches in Connecticut and Virginia are described. (CL)

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State Responsibilities to the Mentally Disabled

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Lexington, Kentucky

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Foreword

Since the late 1940s, the Council of State Governments has published numerous reports on treatment of the mentally ill and the mentally retarded. Recent events, including a number of court decisions, have established a movement toward greater concern for the rights of the mentally disabled.

In 1976, the Executive Committee of the Council selected "state responsibility to the institutionalized" as a priority issue. The present report, prepared by Doug Roederer of the Council staff, is both a response to this priority and evidence of continuing concern by the Council for care of the mentally disabled. It is prepared for state officials charged with determining and discharging state responsibilities to the institutionalized.

Brevard Crihfield
Executive Director
The Council of State Governments

Lexington, Kentucky
December 1976

1. Introduction

The Tenth Amendment to the U.S. Constitution provides that "powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." Traditional state functions include education, law enforcement and correctional institutions, domestic relations, and provisions for the aged, poor, and handicapped. For many years courts were hesitant to make judgments on these matters.

Since 1955, there has been an increase in cases where individuals with grievances have asked the courts to mediate their complaints rather than be satisfied with the more traditional attempts to influence executive or legislative actions. Thus, a variety of civil, criminal, and consumer rights has been established and expanded through court action, particularly at the federal level. Decisions on school desegregation, minimum standards for penal institutions, civil rights of the accused, and those relating to mentally disabled persons clearly indicate the activist direction of the judiciary.

While state officials may want to speculate about whether or not the courts have gone too far in ruling on matters more appropriate to the executive or legislative branches of state government, such speculation does not dismiss the decisions laid down or deal with the issues the decisions address. Although court decisions do not necessarily restrict creative problemsolving by state policymakers, their cumulative effect of expanding the legal rights of the mentally disabled cannot be ignored.

In recent years the courts and State Legislatures have considered and instituted major changes in mental health laws. A strong movement has emerged advocating that adequate treatment for the institutionalized mentally disabled individual is a constitutionally guaranteed right. This emerging point of view has required state officials to look again at the array of services available to these persons.

Questions such as: What is adequate treatment? and, Under what circumstances can or should patients be involuntarily confined? are before state policymakers. In addition, the mix of services in institutions and community-based programs is being considered. These questions are being addressed against the background of well-organized citizen-advocacy groups; strong opinions from attorneys, psychiatrists, and other treatment professionals; and the competition for allocation of state resources.

2. The Mentally Disabled

History

Early thinking about the mentally disabled was that their condition was a result of witchcraft, demon possession, or other mystical phenomena. Therefore, it is not surprising that society's attitude toward these persons was one of fear, misunderstanding, and aversion. The sometimes inhumane confinement of the mentally disabled was justified by claiming that society needed to be protected from those individuals whose behavior was strange and unpredictable.

In the 18th century, the almshouse or workhouse was the primary method of dealing with the poor and aged. Mentally disabled individuals were largely the responsibility of family or friends. When family or friends were unable or unwilling to care for those persons, the community turned to the almshouse. Treatment, of course, was not available in these settings and neglect and abuse were widespread. Legislation was chiefly aimed at protecting society from the violently insane. Those persons incarcerated in jails or prisons were in some cases treated better than the retarded or more passive mentally ill who traveled from community to community as paupers and beggars.

In the early 19th century, the concept of "moral treatment" gained acceptance. Out of humane concern for the mentally disabled, States founded institutions for their treatment. Virginia (1773) and Pennsylvania (1817) founded public facilities for mental patients. In the early 1800s, private hospitals for the mentally ill were established in Connecticut, Maryland, Massachusetts, and New York. State facilities soon followed in Kentucky (1824), South Carolina (1828), Virginia (1828), Massachusetts (1833), Vermont (1836), and Ohio (1838). In the 1840s, Georgia, Indiana, Louisiana, Maine, New Hampshire, New Jersey, and Tennessee opened similar hospitals.

The philosophy behind the establishment of these institutions is interesting in the light of the movement today toward community treatment and support programs allowing the patient to live in or near his own home. At that time it was assumed that large institutions would economically allow all necessary resources for treatment and cure to be brought together. Further, the institutions would allow an individual to be removed from his troubled situation and placed in a quiet, peaceful, usually rural setting conducive to recovery. Not the least of the reasons for the separation and

isolation of these institutions was the fear and disgust on the part of the general population in dealing with the mentally afflicted individual.

In the early years of the operation of these facilities, their populations remained small and some claims were made about success in treatment. With facilities now in operation and claims of success in treatment, state governments began to assume a broad responsibility for assisting the mentally disabled and their families.

This approach quickly led to overcrowding of the facilities. Limited or misdirected knowledge about treatment methodologies and overcrowded conditions resulted in reduced treatment success. With fewer patients successfully discharged, overcrowding was compounded, and custodial care rather than treatment became the norm. From 1900-50, state hospitals and schools for retarded were characterized by overcrowding, inadequate funding, minimum public concern, and long-term custodial care.

In 1946 Congress passed the National Mental Health Act, which authorized research, training, and services to the mentally disabled, and created the National Institute of Mental Health (NIMH) to administer the program. In 1955, through the Mental Health Study Act, Congress authorized the Joint Commission on Mental Illness and Health to look at the human and economic implications of mental health services. This commission recommended increased use of community mental health clinics and was a major impetus in the establishment of these clinics.

In 1962, the Conference of State and Territorial Mental Health Authorities and the National Governors' Conference passed resolutions urging funding for comprehensive state mental health planning. NIMH responded with substantial increases in planning monies. These study commission and planning recommendations focused attention on the need for community-oriented programs to complement existing institutional programs.

In the 1960s, several factors served to emphasize community programs. In 1963 Congress enacted the Mental Retardation Facilities and Community Mental Health Centers Constructional Act. A 1965 amendment added authority for funding of these programs. From 1965-68, $74 million went to States for construction and programs for community mental health centers. In addition, the development and increased use of psychotropic (mind-altering) drug therapy allowed many patients, who before would have been institutionalized, to remain at home or in community treatment settings. Also during this period, other community-oriented programs were developed which substantially increased the number of available community alternatives to institutionalization (see Table 1).

Institutions, on the other hand, also were changing. Many state hospitals and training schools became more treatment oriented, developed more flexible programs aimed at patient needs, attempted to reduce the long-term hard-core populations, and developed more interaction with the

Table 1
Distribution of Mental Health Facilities by Facility Type and State: January 1974*

State or other jurisdiction	Psychiatric hospitals (a)				Community mental health centers (c)	Freestanding outpatient psychiatric clinics (d)	Residential treatment centers (e)
	Total	State and county	V.A. (b)	Private, Nonprofit			
Total	622	321	119	182	399	1,092	340
Alabama	6	2	2	2	7	12	-
Alaska	1	1	-	-	2	3	-
Arizona	4	1	2	30	5	8	4
Arkansas	3	2	1	-	7	5	1
California	45	8	7	1	36	74	42
Colorado	8	3	2	3	11	11	8
Connecticut	13	5	2	6	4	16	11
Delaware	4	3	1	-	2	4	-
Florida	19	5	4	10	14	27	4
Georgia	15	6	2	7	10	33	3
Hawaii	1	1	-	-	3	8	1
Idaho	2	2	-	-	5	3	2
Illinois	27	17	5	5	7	57	16
Indiana	12	9	2	1	5	16	4
Iowa	9	6	3	-	3	26	5
Kansas	7	3	2	2	8	16	3
Kentucky	10	6	2	2	22	1	3
Louisiana	10	3	2	5	11	16	3
Maine	4	2	1	1	6	1	3
Maryland	15	7	2	6	6	34	6
Massachusetts	25	11	4	10	11	48	19
Michigan	28	17	3	8	14	46	21
Minnesota	11	9	2	-	6	23	12
Mississippi	5	2	2	1	7	1	-
Missouri	12	8	3	1	6	9	11
Montana	1	1	-	-	3	3	-
Nebraska	6	4	2	-	3	5	1
Nevada	2	1	-	1	1	4	-
New Hampshire	2	1	1	-	1	10	4
New Jersey	17	12	2	3	11	34	7
New Mexico	3	1	1	1	2	3	1
New York	59	34	11	14	21	141	29
North Carolina	11	4	4	3	15	28	2
North Dakota	1	1	-	-	5	-	-
Ohio	32	21	4	7	10	58	16
Oklahoma	5	3	1	1	3	36	3
Oregon	6	3	2	1	2	23	6
Pennsylvania	39	21	6	12	24	60	11
Rhode Island	4	1	1	2	-	12	3
South Carolina	5	3	2	-	7	8	1
South Dakota	3	1	2	-	1	7	2
Tennessee	13	5	4	4	10	15	2
Texas	24	10	5	9	23	13	14
Utah	2	1	1	-	5	9	3
Vermont	3	1	1	1	2	9	1
Virginia	22	9	2	11	3	34	4
Washington	8	2	4	2	4	37	8
West Virginia	9	7	1	1	5	10	-
Wisconsin	40	32	3	5	7	28	35
Wyoming	2	1	1	-	2	5	2
Dist. of Col.	3	1	1	1	3	2	3
Puerto Rico	4	1	1	2	8	-	-

Table 1-Footnotes

*Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration: National Institute of Mental Health, Division of Biometry and Epidemiology, Survey and Reports Branch, Statistical Note No. 128. Data on the distribution of the 796 general hospitals with any type of separate psychiatric service by geographic region and State are not available.

(a) *Psychiatric hospital* — A public (e.g., State and county, V.A.) or private mental hospital in which the primary concern is to provide inpatient care and treatment to mentally ill persons. Such facilities are licensed as hospitals.

(b) Most of the psychiatric inpatient units in the general medical and surgical hospitals of the Veterans Administration closely resemble psychiatric hospitals both in size and operation. For this reason, these units are grouped with the V.A. neuropsychiatric hospitals and only one category "V.A. psychiatric hospitals" is shown.

(c) *Federally assisted comprehensive community mental health center (CMHC)* — A legal entity through which comprehensive mental health services are provided to a delineated catchment area. This mental health delivery system may be implemented by a single facility (with or without subunits) or by a group of affiliated facilities which make available at least the following essential services: inpatient, partial, outpatient, emergency care, and consultation and education. Further, one of the component facilities of the CMHC is the recipient of federal funds under P.L. 88-164 (construction) or P.L. 89-105 (staffing), or amendments thereto.

(d) *Outpatient psychiatric clinic* — An administratively distinct facility whose primary purpose is to provide nonresidential mental health service and in which a psychiatrist usually assumes medical responsibility for all patients or directs the mental health program.

(e) *Residential treatment center for emotionally disturbed children* — A residential institution that primarily serves children who by clinical diagnosis are moderately or seriously disturbed emotionally and provides treatment services usually under the supervision of a psychiatrist.

community programs mentioned above. One of the most notable changes in state facilities during this period was the discharge from these institutions of many elderly patients not in need of psychiatric care.

Definitions and Available Services

The term "mental disability" has been used to describe a wide range of behaviors and conditions. Two generic groupings can be made of those who are mentally disabled—the mentally ill and the mentally retarded, the latter included under those referred to as developmentally disabled.

The Mentally Ill

A strict definition of mental illness is difficult to formulate. People who exhibit behavior outside of established norms are commonly referred to as insane, psychotic, crazy, deranged, etc. These people are called mentally ill when their behavior reaches some point or degree outside of established norms.

Some have argued that (1) the mental illness label is publicly degrading to the individual and reduces his self-esteem; (2) attention to the mind as the locus of the problem too easily eliminates other factors in the environment as the problem; (3) the term "illness" incorrectly suggests that a physician provides treatment rather than a marriage counselor, employment counselor, etc.; (4) a false concept of mental illness as special and mysterious suggests that a special treatment facility such as an institution provides treatment and segregation from others.

In lieu of a strict definition, mental illness can be viewed as man's problem in living. Everyone experiences these problems and an individual's ability to confront and solve these problems varies. Reactions outside of established or accepted norms identify those individuals who need assistance. Mentally ill persons or those experiencing problems in living

may have continuous or periodic episodes of depression, acute anxiety, personality disorders, psychosis, problems relating to others, etc.

State programs designed to assist individuals in solving such problems should take into account a full range of solutions such as income assistance, employment, counseling, education, etc. To remove the individual completely from his situation and make him totally dependent on services in an institution should be done only after serious consideration. In most cases where complete institutionalization is required, the individual should be provided with such assistance as to facilitate his return to the community as soon as possible.

While average daily institutional populations are declining (see Table 2), state hospitals continue to serve the most severely troubled patients. Many private community hospitals now have psychiatric units and are able to function as part of the array of community alternatives to longer-term institutionalization. In addition, day only or night only hospitalization is used more widely for the individual who can function at a job, etc., but needs assistance during evenings and weekends, or the individual who can live at home but needs assistance during the day.

Halfway houses, group homes, foster homes, and similar situations are increasingly available to individuals who cannot live independently at home but who do not require full institutional services. The number and variety of community services which serve the individual who lives at home have increased substantially. Community mental health centers offer alcohol and drug counseling, marriage and family therapy, group and individual counseling, telephone "crisis lines," etc. Other services not traditionally considered mental health-related include social and employment services, vocational counseling, and financial assistance.

The Mentally Retarded

"Mental retardation," as defined by the American Association on Mental Deficiency, "refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period." An estimated 6 to 7 million persons in the United States are mentally retarded. Since the passage of the Developmental Disabilities Act in 1970, this definition has been broadened. The 1970 law defines developmental disability as a "disability attributable to mental retardation, cerebral palsy, epilepsy, or another neurological condition . . . which . . . originates before . . . age eighteen, which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individuals."

Thus the term developmental disability includes mental retardation, epilepsy, and cerebral palsy. Each of these disorders is likely to be accompanied by multiple handicaps and is likely to require specialized long-term services from several providers. The following discussion

Table 2
Number of Patients and Additions to Inpatient Services, and Daily Expenditures per Resident Patient of State and County Mental Hospitals: 1973 and 1975*

State or other jurisdiction	Number of patients (a)		Number of additions (b)		Daily expenditures (c)	
	1973	1975	1973	1975	1973	1975
Total	248,516	193,436	442,516	435,136	$25.20	$37.54
Alabama(d)	3,810	2,534	4,000	3,214	16.09	30.78
Alaska	146	115	521	671	64.15	95.64
Arizona(e)	779	673	1,416	1,503	38.35	51.46
Arkansas(e)	538	421	2,779	2,867	58.93	89.96
California(e)	9,439	9,405	29,159	28,607	32.10	45.58
Colorado(e)	1,454	1,298	5,793	6,543	41.64	56.23
Connecticut	3,623	3,299	15,312	16,455	32.69	45.04
Delaware	1,169	853	2,404	2,039	24.35	35.44
Florida	6,963	6,392	6,875	8,019	17.98	25.95
Georgia(e,f)	8,604	6,507	19,036	24,703	21.53	37.67
Hawaii(e)	236	214	722	791	67.32	46.60
Idaho(e)	270	216	1,107	1,146	34.71	44.99
Illinois(g)	10,373	7,053	25,211	25,278	43.98	57.21
Indiana	6,039	4,581	9,799	8,698	20.72	29.50
Iowa	1,212	1,269	5,469	5,253	46.27	49.70
Kansas	1,826	1,475	4,893	4,327	35.18	50.40
Kentucky(h)	1,161	686	2,040	1,263	20.20	37.56
Louisiana(e)	3,327	2,577	7,790	9,520	20.13	31.89
Maine(i)	1,286	786	1,605	1,321	25.08	49.20
Maryland(e)	6,315	5,244	14,333	12,236	24.92	36.22
Massachusetts(g)	7,842	5,272	16,658	13,383	27.98	43.50
Michigan(e)	7,361	5,076	16,386	14,924	34.05	57.99
Minnesota(k)	4,360	4,064	9,003	7,829	23.52	34.16
Mississippi	4,176	3,669	6,131	5,950	9.99	13.47
Missouri	5,228	3,817	20,161	18,124	30.05	39.91
Montana(e)	1,066	604	2,619	1,962	16.47	26.93
Nebraska	839	748	3,563	3,691	48.68	61.05
Nevada	355	264	838	775	31.96	42.95
New Hampshire	1,446	1,184	1,456	1,197	19.02	35.69
New Jersey	11,849	9,467	14,860	13,844	24.14	33.96
New Mexico(e)	450	337	2,246	1,912	20.93	35.37
New York (e,l)	44,963	35,704	37,498	37,649	24.03	37.09
North Carolina	5,805	4,642	15,381	17,733	24.09	40.97
North Dakota	632	592	1,589	2,232	25.28	36.63
Ohio(e)	12,903	9,903	22,518	19,939	23.56	32.57
Oklahoma(e)	2,715	2,239	7,071	7,758	20.12	30.07
Oregon	1,405	1,183	6,217	5,265	25.55	33.50
Pennsylvania(e)	19,023	15,005	11,093	8,111	30.14	46.00
Rhode Island(e)	1,770	1,597	5,189	5,025	20.27	26.52
South Carolina	5,346	4,097	5,929	4,729	11.18	21.71
South Dakota(e)	942	673	1,882	1,735	17.04	29.29
Tennessee	4,918	4,292	10,314	11,935	19.03	28.89
Texas(m)	9,937	7,467	25,610	26,061	15.42	26.56
Utah(e)	265	297	499	603	37.20	45.14
Vermont	701	489	1,339	1,021	26.86	42.68
Virginia(e)	7,877	6,473	14,175	15,215	14.06	23.57
Washington(e)	1,800	1,266	4,131	3,619	31.78	40.31
West Virginia(e)	3,507	2,849	4,924	4,127	12.53	17.54
Wisconsin(n)	6,798	1,227	7,680	8,229	24.49	N.A.
Wyoming	304	276	746	761	27.86	43.61
Dist. of Col.(e)	2,921	2,825	4,124	5,344	52.50	68.42

Table 2-Footnotes

*Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration; National Institute of Mental Health, Division of Biometry and Epidemiology, Survey and Reports Branch, Statistical Note No. 132, July 1976.

N.A.—Not available.

(a) Includes all persons who were physically present for 24 hours per day in the inpatient service at the end of the year or who were away on short visits as long as they were expected to return to the inpatient service.

(b) Includes returns from extended leave (e.g., from family care, family placement, convalescent leave, etc.) as well as first admissions and readmissions. If a person was admitted more than once during the year, each admission was counted separately.

(c) The ratio of expenditures per average daily resident patient has been the most commonly used ratio for comparing mental hospital expenditures. Its major limitation is that it does not adequately take into account the number of additions for which a large share of the expenditure is required.

(d) Data covers the fiscal year ending September 1975.

(e) Overestimated, generally because expenditures are for entire hospital staff or because patients from federally funded community mental health centers are included.

(f) Admissions do not include patients transferred from public retardation facilities.

(g) Partially estimated.

(h) The decrease in inpatients at the end of the year in Kentucky was due essentially to one hospital being operated by a community mental health board rather than being included in the state mental health systems as in previous years.

(i) Patients from federally funded comprehensive community mental health center(s) affiliated with the state mental hospital(s) are excluded from data related to patient movement but included in data pertaining to staffing and expenditures.

(j) Returns from long-term leave and discontinuations include persons on unauthorized absence and escape.

(k) While the state mental hospitals in all States have to a lesser extent been used to care for disability groups other than the mentally ill, this has occurred to a much greater degree in Minnesota.

(l) 1975 data is for the fiscal year April 1, 1974 to March 31, 1975 (for one hospital reporting began June 17, 1974).

(m) For most hospitals, the reported data is for the fiscal year ending August 31, 1975. Also, data includes patients from federally funded comprehensive community mental health center(s) affiliated with state mental hospital(s). The number of days of inpatient care provided during the year at the Texas Research Institute of Mental Sciences is not available; therefore, in computing the daily maintenance expenditure for this facility, $3,611,103 was omitted.

(n) Profound structural change in the delivery of mental health services in the State caused a drastic decrease in the number of resident patients at the end of the year. Wisconsin statutes placed the responsibility of developing and delivering mental health services in the communities with financial assistance from the State.

concerns itself with the mentally retarded, although the services provided equally apply to others in the developmentally disabled category.

Many human problems require a particular service for specified lengths of time. For example, the unemployed individual may need only employment services until a job is located; a family may need day-care only until the child has reached a certain age. For the mentally retarded, the assumption is that a wide range of services is required, a certain degree of coordination is essential, and the services need to provide long-term support for the individual and possibly his family. The degree of retardation may range from mild, requiring few or occasional services, to profound, requiring constant care in community or institutional facilities.

Institutional care for the mentally retarded is provided in mental health hospitals, training schools, and private facilities providing long-term custodial care. State institutions for the retarded now serve approximately 175,000 individuals.

Group homes and other forms of community-based residential services for the mentally retarded are used increasingly for individuals who can function partially in the community but require certain support services. This has led to a reduction in the resident population of the mentally retarded in public residential facilities (see Table 3).

The services utilized by the mentally retarded individual in the community are as varied as the range of available services: income, employment, vocational rehabilitation, mental health, and health services.

Table 3
Population Trends in Public Residential Facilities for the Mentally Retarded: 1970 to 1975*

State or other jurisdiction	Resident population as of: July 1970	Jan. 1975	Total increase/decrease	Percentage increase/decrease
Total	186,743	167,652	- 19,091	- 10.2
Alabama	2,300	1,762	- 538	- 23.4
Alaska	109	110	+ 1	+ 0.9
Arizona	971	1,050	+ 79	+ 8.1
Arkansas	1,294	1,520	+ 326	+ 25.0
California	11,483	10,000	- 1,483	- 12.9
Colorado	2,113	1,700	- 413	- 19.5
Connecticut	4,074	3,500	- 574	- 14.0
Delaware	568	575	+ 7	+ 1.2
Florida	6,128	5,509	- 619	- 10.1
Georgia	1,864	3,568	+ 1,704	+ 91.4
Hawaii	747	712	- 35	- 4.7
Idaho	654	465	- 189	- 28.9
Illinois	7,877	6,800	- 1,077	- 13.7
Indiana	3,604	3,000	- 604	- 16.7
Iowa	1,623	1,460	- 163	- 10.0
Kansas	2,016	1,658	- 358	- 17.7
Kentucky	989	945	- 44	- 4.5
Louisiana	2,959	3,800	+ 841	+ 28.4
Maine	799	586	- 213	- 26.7
Maryland	4,215	3,800	- 415	- 12.9
Massachusetts	7,554	6,000	- 1,554	- 20.5
Michigan	11,834	7,100	- 4,734	- 40.0
Minnesota	4,321	3,600	- 721	- 16.7
Mississippi	1,340	2,332	+ 992	+ 74.0
Missouri	2,535	2,567	+ 32	+ 1.3
Montana	944	550	- 394	- 41.7
Nebraska	1,759	1,000	- 759	- 43.1
Nevada	N.A.	N.A.		
New Hampshire	970	740	- 230	- 23.7
New Jersey	6,846	7,500	+ 654	+ 9.5
New Mexico	708	780	+ 72	+ 10.1
New York	26,551	19,854	- 6,697	- 25.0
North Carolina	5,068	4,300	- 768	- 15.1
North Dakota	1,497	950	- 547	- 36.5
Ohio	9,462	8,000	- 1,462	- 15.4
Oklahoma	1,934	2,100	+ 166	+ 8.6
Oregon	2,836	2,160	- 676	- 23.8
Pennsylvania	10,621	10,000	- 621	- 5.8
Rhode Island	851	839	- 12	- 1.4
South Carolina	3,633	3,600	- 33	- 0.9
South Dakota	1,197	1,180	- 17	- 1.4
Tennessee	2,785	2,500	- 285	- 10.2
Texas	11,037	13,200	+ 2,163	+ 19.5
Utah	863	850	- 13	- 1.5
Vermont	628	466	- 162	- 25.7
Virginia	3,661	4,900	+ 1,239	+ 33.8
Washington	3,738	2,500	- 1,238	- 33.1
West Virginia	461	500	+ 39	+ 8.4
Wisconsin	3,781	3,000	- 781	- 20.6
Wyoming	699	600	- 99	- 14.1
Dist. of Col.	1,242	1,364	+ 122	+ 9.8

*Source: *Mental Retardation: Trends in State Services*, President's Committee on Mental Retardation, 1976.
N.A.—Not available.

3. Legal Issues

In the 1960s, several factors had significant impact on state services to the mentally ill and mentally retarded. A concern for the legal rights of patients greatly influenced state institutional programs. Court decisions relating to commitment procedures and upgrading of facilities and establishing or updating treatment standards necessitated revisions of statutes and substantial increases in appropriations. These decisions have, in many cases, put States in the position of scrambling to meet certain imposed requirements. In the process of scrambling it has not always been possible to systematically assess needs and design new programs to meet those needs. This is not to suggest that the court rulings were not timely, appropriate, or necessary. The point being made is that the court decisions have placed these issues high on the agenda of state concerns.

Volumes have been written in legal and psychiatric journals about these court rulings and their implications for law and psychiatry. This attempt is to spotlight significant decisions and assess their implications for state legislators and officials.

Right to Treatment

Dr. Morton Birnbaum, an attorney and physician, is credited with initiating discussion of the right-to-treatment concept. He was concerned about inadequacies in many public mental health facilities and wanted to focus public attention on these conditions. In 1960 he proposed that the courts determine whether or not persons institutionalized for mental illness actually were receiving treatment adequate to overcome such illness and thereby regain their health and liberty.[1]

The first court decision to deal with the right-to-treatment question was *Rouse v. Cameron*.[2] This case involved Charles Rouse, who had been acquitted by reason of insanity on a misdemeanor (carrying a dangerous weapon). He was committed to a mental health hospital in the District of Columbia to receive treatment for a condition (insanity) which was the basis for his being acquitted. Four years later his petition for habeas corpus was upheld by a U.S. Court of Appeals. The court held that if the individual is not receiving treatment, then he is actually in a penitentiary although not convicted and not sentenced to a specified term. The court's recognition of right to treatment was based on a statutory provision.

The maximum penalty for the crime Mr. Rouse was charged with was one year. He was detained involuntarily, however, in the mental health hospital for four years. According to proponents of the right-to-treatment argument, since the only reason for Mr. Rouse's confinement was the need for treatment, the absence or inadequacy of such treatment additionally raises constitutional questions of due process, equal protection, and cruel and unusual punishment.

A constitutional right to treatment was asserted in the case of *John W. Nason* v. *Superintendent of Bridgewater State Hospital.*[3] The plaintiff argued that in his five years of confinement he had received no treatment but only minimum custodial care. His petition asked that he be transferred to another facility where treatment would be available. Mr. Nason had been committed to Bridgewater, a Massachusetts Department of Corrections' facility for the dangerously insane, in 1962 when he was judged not competent to stand trial on a criminal charge. A specially appointed commissioner's ruling (later upheld by the Massachusetts Supreme Judicial Court) provided that an appropriate plan of treatment be determined and implemented for Mr. Nason. While the commissioner found that staff at the facility was inadequate and that Mr. Nason was not receiving treatment, no specific directives were issued either for his treatment or for the hospital generally. The court ruling suggested that serious questions of deprivation of liberty were raised if treatment was not provided.

The class-action case of *Wyatt* v. *Stickney*[4] not only raised the issue of involuntary detention without treatment, but also opened the door on the issue of court-imposed minimum standards for public facilities for the mentally handicapped. The case was initiated when 99 employees of the Bryce State Hospital in Alabama were to be laid off due to budget cuts. The focus of the case rapidly shifted, however, to the level of treatment in Alabama's state mental hospitals. The district court's March 1971 ruling concluded that the hospitals' treatment program was below expected standards. Noting that patients at Bryce Hospital were committed, in many cases, through noncriminal procedures, the court held that such patients have a constitutional right to treatment which affords an opportunity for cure or improved mental condition.

The court ordered the Department of Mental Health to submit a plan under which the program of the hospital would include appropriate and adequate treatment. The case was then enlarged to include the State's other mental health/mental retardation hospitals in addition to Bryce.

The court determined that adequate treatment could be judged in three broad areas. These included certain environmental minimums (such as physical and psychological conditions), quality and quantity of staff, and individualized treatment plans.

In addition to these general conditions for adequate treatment, the court set out lengthy and specific standards for patients' privacy, dignity,

communication with outsiders, limit on medication, restraint, experimentation, conditions for interaction with other patients, and compensation for labor. Other requirements concerned physical facilities, sanitation, nutrition, staff-to-patient ratios, and educational opportunities. Finally, the court spelled out that individualized treatment plans would include criteria for transfer to a less restrictive continement, including discharge.

In its decision specifically relating to the hospital for the mentally retarded, the court concluded that there was a constitutionally guaranteed right to individual "habilitation" for the mentally retarded. Habilitation refers to the process by which the patient is assisted in learning to care for himself and respond to his environment. Habilitation suggests learning of interactional and social skills and includes formal, structured education, while treatment implies primarily a medical dimension.

The court decision in the *Wyatt* case assumes that the best means of assuring adequate treatment is to establish standards for the physical facilities and staff/patient ratios. Some have questioned the courts' ability to assess the adequacy of treatment. Others raise questions more specifically directed to the specific standards set out in *Wyatt*. Legislatures seem to be in a better position than the courts to set and monitor such standards.

Right to the Least Restrictive Alternative

The right to the least restrictive alternative is a variation of the right-to-treatment concept. The basis for this argument is a U.S. Supreme Court decision, *Shelton* v. *Tucker*, which stated that "even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved."[5]

Several years later this decision was applied to the civil commitment process in *Lake* v. *Cameron*.[6] The court's decision in this case was that before an individual could be committed full time to a mental institution, the court was responsible for considering alternate placements that would require the patient to give up fewer personal liberties. The least restrictive alternative applies to individuals already in hospitals (deinstitutionalization) and to those before the court under civil commitment procedures.

In *Lessard* v. *Schmidt*, a challenge to Wisconsin's civil commitment procedures, the court ruled that "the person recommending full-time voluntary hospitalization must bear the burden of proving (1) what alternatives are available, and (2) what alternatives were not deemed suitable."[7]

Generally, the reasons for hospitalization include (1) providing care and treatment, (2) protecting the individual from himself, and (3) protecting others from the individual. The courts have ruled that in attempting to implement reasons (1) and (2), unnecessary deprivation of personal liberties

is to be guarded against. Protecting others from the individual requires a capability to predict who is dangerous, which will be discussed later.

Even if there is no argument about the legal basis for the right to the least restrictive alternative, there is considerable difficulty in implementing the legal principle. The courts have placed the responsibility for showing what alternatives are available and why they are not suitable upon the person seeking the commitment. Courts are not likely to be aware of all community alternatives and have little basis for understanding the diagnosis or the most appropriate treatment. A number of possibilities have been suggested for carrying out a search for alternatives and recommendations to the court. These include staff hired by the court similar to probation officers in criminal cases, staff of community mental health centers under contract to the court, staff from a particular state hospital, or an independent information and referral agency whose services would be made available to the client.[8]

The right to the least restrictive alternative was addressed in 1975 by Congress in the Developmental Disabilities Assistance and Bill of Rights Act.[9] In delineating rights of the developmentally disabled, the act provides that treatment, services, and habilitation be provided in the setting least restrictive of the person's personal liberty.

Right to Education

In the discussion of right to treatment, it was noted that for the mentally retarded this included a right to habilitation—the right to receive assistance that would enable the individual to become more self-sustaining. Proponents of the right-to-education argument suggest that education is a basic and fundamental part of habilitation.

The importance of education in our society is widely recognized. The U.S. Supreme Court, in *Brown v. Board of Education*,[10] pointed out education's integral role in preparing individuals to assume basic responsibilities and to adjust normally to the environment.

The case of *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania*,[11] through a consent agreement between the parties, ordered that all mentally retarded children in Pennsylvania be provided with a free program of education appropriate to their learning capabilities. The three-judge federal district court noted that all mentally retarded persons could benefit from a program of education and training and that most could eventually achieve self-sufficiency. The court also noted the positive impact of such programs, if begun early in the life of the retarded individual.

The court concluded that since the Commonwealth of Pennsylvania was providing a free public education to all children, including exceptional children, similar education and training could not be denied to mentally retarded children.

While every State has education statutes that require compulsory attendance, many children do not receive an education. In some cases this results from the child being assessed as unable to benefit from education. In other cases, the need for special education is recognized but the program is not available. The U.S. Office of Education estimates that up to 8 million children have a physical or mental handicap requiring special education attention.

Most States have legislation mandating special education for all retarded children, regardless of the nature of the handicap. Implementation of this mandate is difficult. Special education classes are expensive and are funded generally at the expense of a program which is desired by another segment of the strong education lobby. Special education usually requires specially equipped facilities, lower staff-pupil ratios, and other considerations such as transportation. Special education does not necessarily imply separate classes. In recent years, the practice of integrating physically and mentally handicapped children into regular classes—mainstreaming—has gained acceptance. The Education for All Handicapped Children Act, in addition to requiring that every child be provided with some form of public education, clearly supports the mainstreaming movement.[12]

The push for right to education applies not only to those in institutions, but also to those at home or in community facilities. The *Wyatt* decision, discussed earlier, provided that the institutionalized be offered opportunities for education and training regardless of age or disability.

Right to Liberty

The clear majority (up to 90 percent in some States) of new admissions to state mental institutions are persons who are hospitalized involuntarily. The States have this authority from three basic sources. One is police power which authorizes the State to protect society from individuals who are dangerous and threaten the safety of others. Another is the doctrine of parens patriae which authorizes the State to act as parent or to intervene in situations where the individual cannot care for himself. Finally, States have intervened in situations where the individual required protection from harm he might bring to himself.

State legislation determines the criteria for involuntary commitment. In general, however, state legislation is extremely vague on defining specific criteria and is often criticized for leaving too much to medical judgment. A 1974 survey of state legislation found commitment possible if a person was judged mentally ill and "dangerous to himself" or others (29 States), unable to care for his physical needs (15 States), in need of care and treatment or a fit subject for hospitalization (29 States, with 13 requiring that the person be unable to make a responsible treatment decision), and requiring commitment for his own or others' welfare (7 States).[13]

Generally, definitions for terms such as "dangerous," "in need of care or treatment," "mentally ill," and "incompetent" are vaguely defined, if at all. Vague definitions mean that judges, attorneys, physicians, and the individual's family have inconsistent powers to argue for commitment. The resulting abuses have caused considerable pressures for change for more explicit language in state statutes.

Procedures for involuntary commitment vary widely. Provisions for emergency hospitalization are often not strict or burdensome, on the theory that the individual may need rapid attention to protect himself or others. Such emergency detention can be accomplished without a judicial hearing and frequently only requires two or more physicians' concurrence. While the maximum period for such detention is usually five to 10 days, in some States it can last for up to 60 days. Short-time or longer-term commitment takes a variety of procedural forms in the States, from a judicial hearing to a hearing before a panel of experts, including physicians. These hearings are often informal, with only loose statutory provisions governing their conduct. Again, the looseness and informality of these proceedings have led to certain abuses now being addressed by the courts.

The direction provided by the courts is illustrated in *Lynch* v. *Baxley*,[14] an Alabama decision issued in December 1974. A three-judge court overturned the State's commitment procedures with substantial consequences to the state mental health system. The court set out due process requirements for commitment, including:

(1) Adequate notice of the hearing;

(2) The presence of the person proposed to be involuntarily committed;

(3) The right to counsel or the appointment of counsel, if indigent;

(4) The following requisite findings to support an order of commitment:

(a) the person to be committed is mentally ill,

(b) the person to be committed poses a real and present threat of substantial harm to himself or to others,

(c) the danger posed by the person to be committed has been evidenced by a recent overt act, and

(d) there is treatment available for the illness diagnosed;

(5) The proposed commitment is the least restrictive alternative necessary and available for the person's illness;

(6) That the standard of proof required for commitment is clear, unequivocal, and convincing evidence;

(7) That the person be given the opportunity to offer evidence in his own behalf, have the opportunity to be confronted with and to cross-examine the witnesses testifying in support of commitment, and the privilege against self-incrimination; and

(8) That there be a full record of the commitment proceeding.

As a result of this decision, over 3,000 commitment hearings were held for persons then confined in Alabama institutions. About one third were involuntarily recommitted, roughly 700 were transferred to other facilities, and over 1,300 were discharged.

The direction of these court decisions seems clear. It will be more difficult to involuntarily commit individuals to state mental health hospitals, and the number and percentage of such admissions will decline. This change is welcomed by many state mental health professionals who complain that facilities have been used as a dumping ground for persons who do not need confinement in these types of institutions.

Dangerousness

A frequently applied but most troublesome concept in commitment proceedings is the determination of dangerousness. The ability to predict whether or not a particular individual will be dangerous is extremely difficult. This prediction is largely left to psychiatrists, who are under fire for their low degree of accuracy.

> A famous example is the so-called Operation Baxstrom. In New York in 1966 there were almost 1,000 mentally ill ex-convicts whom psychiatrists had examined and certified as being so dangerous that they could not be accommodated in regular civil mental hospitals. The psychiatrists predicted that they could only be handled in high-security mental hospitals run by the Department of Correction. Nevertheless, because of a Supreme Court decision (*Baxstrom* v. *Herold*), all of those patients were transferred to civil mental hospitals. Because the psychiatrists had predicted that those patients would be unusually dangerous, the employees of the civil hospitals threatened to resign and demanded higher wages. The psychiatric predictions turned out to be almost 100 percent wrong. After one year the Department of Mental Hygiene reported that "there have been no significant problems with the patients. All have been absorbed into the general patient population, many reside in open wards, over 200 have been released, and only seven have been certified as too dangerous for a civil hospital."[15]

The question is, How many persons diagnosed as dangerous who have not engaged in violent acts are we willing to detain in order to detain that one person who actually is dangerous? The response in some States has been to require that a dangerous act be observed rather than rely on a prediction that a violent act is likely.

Additional direction on the right-to-liberty question, which also involves the concept of dangerousness, is provided by a 1975 decision by the U.S. Supreme Court in the case of *O'Connor* v. *Donaldson*.[16] An involuntarily committed patient in a Florida state institution for 15 years, Mr. Donaldson claimed that he was not dangerous to himself or others, that he

was not receiving treatment, and that he was being deprived of his constitutional right to liberty.

The court did not rule on the patient's right to treatment or on the criteria or procedures under which he was committed. The court did rule that a civilly committed patient has a right to liberty if he is not dangerous to himself or others, is receiving only custodial care, and is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.

While the decision directly mandated no action other than the release of Mr. Donaldson, its implication for States is substantial. It suggests, in support of previously discussed decisions, that States should reevaluate procedures for involuntarily confining nondangerous persons. Further, the decision suggests that institutions periodically review cases to determine (1) if treatment is being received, and (2) if the individual continues to require hospitalization.

Voluntary Admissions

The percentage of voluntary admissions in many States is increasing. Theoretically, voluntary admission answers the problem of the legal rights of the involuntarily committed. However, there are those who argue that voluntary commitment is often "agreed to" by individuals under the threat of involuntary commitment proceedings. Another argument is that once admitted voluntarily, the patient is frequently involuntarily retained in the institution. In most States, the voluntary patient who requests his release must be discharged in 48-72 hours unless the hospital initiates involuntary retention proceedings.

Rights of Hospitalized Patients in Institutions

Patients who are hospitalized in institutions have already given up certain rights. Further, effective care and treatment of hospitalized patients require that certain privileges not be extended. However, there are a number of rights which have in some instances arbitrarily been withdrawn from people in institutions or have unnecessarily been left to the discretion of hospital authorities.

Communication

Communication through written correspondence and visitation has been expanded through changes in state statutes in recent years. The only area decided by the courts has been that of the patient's right to unrestricted correspondence with his attorney. Administrators are usually responsible for communication policies, but the ward staff is responsible for implementing and monitoring the policy. Since communication outside the institution can in some instances be upsetting to the patient, there is a

tendency to restrict communication which by statute or hospital policy should be allowed.

Restraints

Mechanical restraints were in wide use 100 years ago. More humanitarian approaches to the institutionalized have discouraged the use of restraints. Roughly one half the States limit or regulate the use of restraints. As with communication rights, the decision to use restraints is sometimes made by staff and not by administrators who make policy. One safeguard is to require that use of restraints be recorded in patient records and periodically updated or reviewed by appropriate authorities. One form of restraint particularly subject to abuse is seclusion. Seclusion is specifically prohibited in the *Wyatt* decision.

Chemotherapy

Drugs used as tranquilizers are a potential problem. There have been suggestions that a significant abuse of patients' rights occurs in the indiscriminate overuse of drugs to quiet patients. The involuntary medication of objecting patients without proper judicial safeguards is of concern to those advocating patients' rights.

Surgery

Restrictions on the use of brain surgery or lobotomy is not spelled out in the statutes of most States. Some States require consent of the patient or guardian while others require only notification. Similarly, electroshock treatment is not addressed in all statutes and its use can be abused.

Patient Labor

Patients are frequently used to perform tasks required for the continued operation of the hospital. Some tasks, particularly personal housekeeping and vocational training, are obviously therapeutic. In other cases, patients' rights may be abused by forcing an individual to perform menial tasks useful only in maintaining the hospital. It is this coercion to perform tasks that otherwise would be the responsibility of employed personnel that has recently been raised as an issue of patients' rights. The courts have also addressed the question of patients' rights to receive minimum wages for work performed.

Other Issues

Other questions about the control of the patients' property, guardianship, restrictions on sexual behavior, contraceptives, and sterilization are crucial concepts. Whether consent is by the patient, a parent, legal guardian, or institution is critical. Voluntary sterilization, for example, where the consent is by a third party, may in fact be involuntary.

4. Deinstitutionalization

For most state officials concerned about services for the mentally disabled, the term "deinstitutionalization" provokes strong opinions. It is heralded by some as the salvation of those in institutions and it is condemned by others as a cruel hoax for those it seeks to assist. Without question, in many instances its purposes and outcomes are misunderstood. Deinstitutionalization can be examined at two levels.

For the individual, deinstitutionalization is the process of overcoming his dependence on the institution and adapting to community living. The institution offers a secure, isolated world where activities are routinized and needs are anticipated and provided for. Leaving the institution can foster fears of the unexpected and fears of assuming responsibility for tasks the patient may at first not know how or be able to handle. In the field of mental disability, professionals refer to normalization as the process of assisting patients to develop accepted and established patterns of behavior so that the individual can return to and be successful at community living. Institutional placement, particularly if it emphasizes custodial care, is seen as an impediment to retraining for independent community living.

For state program planners and decisionmakers, deinstitutionalization is the process of redirecting resources to provide programs that address patients' needs in the community as an alternative to full-time, long-term institutional care. This process is the intended focus of this discussion.

In the 1960s, public and professional opinion began to center on the negative effects of institutions. The exposure of overcrowded, unsanitary, and questionable therapeutic conditions shocked the public. Questions were raised about the lack of efficiency in a system that severed family ties, made the individual more dependent the longer he remained in the institution, and destroyed ties with the community that were the individual's only hope for eventual independence and self-sufficiency.

Several States adopted a policy of deinstitutionalization. In some States it was solely an initiative of the mental health/mental retardation agency; in other cases the policy had strong gubernatorial and legislative support. Large institutions, many of which had been in operation 40 years or more, it was argued, were costly to maintain and difficult to administer. Issues of costs vs. effectiveness of treatment convinced many decisionmakers that institutions should be phased down or closed in favor of smaller, community-based, out-patient or short-term inpatient facilities.

In the mid-1950s, there were between 500,000 to 600,000 individuals in state mental health hospitals. In the 20 years since, this figure has been cut roughly in half. In the decade preceding 1973, for example, New York reduced its hospital population by 46,000, California by 48,000 and Massachusetts by 17,000.

This reduction occurred despite an increase in the number of new admissions. New admissions increased steadily up to 1969 and then began to decline. The biggest reason for the drop in state hospital populations has been the reduction in the average length of stay for patients. The discharge of many long-term patients has contributed to this trend. The number of patients treated in Veterans Administration hospitals and in general hospital psychiatric units has increased during this period.

One might expect that the establishment and growth of community mental health centers were a major factor in the decline of state hospital populations. This is not necessarily the case. Most of the patients who would otherwise be in state hospitals are now being served in nursing homes, boarding homes, or intermediate care facilities. These facilities, while more community-based than state institutions, are generally long-term, custodial care in nature.

Some argue that community mental health centers have had a role in preventing new admissions through early detection, treatment, and location of alternative resources and placements. Yet, despite the phasing down or closing of a number of state hospitals, the total number of state hospitals has remained constant with the opening of new facilities in several States.

The movement to deinstitutionalize the delivery of state mental health/mental retardation services has not progressed without opposition. State hospital employees are among the groups voicing the most persistent opposition. The state hospital is often the major employer in a community, particularly in the rural areas where these facilities are frequently located. In studies where facilities have been closed, 40 to 60 percent of the employees have generally been able to transfer to other state facilities. This transition can be eased in cases where state corrections, juvenile, or education programs take over the abandoned mental health facility and offer employees an opportunity to remain. Employees of closed facilities have requested the opportunity to transfer at equal or better pay, relocation assistance, and retraining opportunities. Parents and other relatives of the institutionalized often join those opposed to deinstitutionalization. Often they fear the loss of what has been the answer to difficult-to-handle relatives or experience guilt over having originally placed their children in institutions and now realize that their functioning outside an institution is a real possibility.

Communities losing such a facility are concerned about the effects on the community economic base. In addition to food and other supplies the

hospital purchases in the community, there are hundreds of employees who utilize housing, automobiles, and numerous services available in the community. Local government officials along with state legislators from the area can generate considerable opposition to a hospital closing.

Residential communities, where alternatives to institutions such as group homes or halfway houses can be located, have voiced opposition to locating services in their area. Zoning laws, housing codes, and health, fire, and safety regulations often prohibit certain alternative facilities from operating.

What may be referred to as budget inertia can complicate the deinstitutionalization process. If a facility is being phased down, there continues to be cost for maintenance, staff, food, etc. Release of large numbers of patients may not have a significant effect on these expenses. Further, the staff cost of discharge and placement are generally greater over the short run than continued institutional custody. If the cost of the institution remains constant, then it is difficult to justify the additional dollars necessary for developing community alternative programs. In cases where millions of dollars have been spent in the past five to 10 years on updating or remodeling an institution, it is difficult to argue that the facility is now no longer needed.

One of the complaints raised by those opposing deinstitutionalization is the lack or poor quality of resources available in the community. Abuses in privately operated nursing and boarding homes have been cited. Neglect of patients' needs in some of these homes has been alleged to be much worse than the claims of neglect in overcrowded, understaffed state institutions. Other services have not in all cases provided the required community alternatives. The community mental health center program has not developed the wide network of centers that was predicted. Coordination of other human services (employment, health, vocational training, and family counseling) so important to the successful community placement of a former institutionalized patient is widely recognized as a major shortcoming. Other roadblocks to deinstitutionalization include disincentives related to federal funding, transportation problems, accessibility to and eligibility for community services, and lack of acceptance of mentally or physically handicapped individuals.

With the exception of a few determined advocates of deinstitutionalization, most professionals agree on the continuing need for public institutions to serve some part of the mentally ill and mentally retarded population. There are proposals for new or modified roles for existing or newly constructed facilities. Some of the new residential service facilities are being located in more urbanized areas. In these situations, institutional services are just one of an array of services offered, including inpatient, outpatient, and home-based services, community education, and many more.

Some older residential f.cilities are being converted into specialty institutions providing a particular service for a special type of patient. The need for such a service is determined by an agency located in the community. Patients are admitted only long enough to attain a predetermined level of functioning and are then released.

Other States have utilized institutional services as regional centers serving a particular area of the State. These centers interact closely with all community services in the area. The institution may provide specialized services, such as diagnosis and evaluation, or long-term inpatient care as required.

Deinstitutionalization is not just a theoretical notion. Most States and many localities have had some experience over the past few years in attempting to institute such a policy. The following examples reflect these attempts.

The Connecticut Experience

Connecticut adopted a policy of deinstitutionalization in the early 1960s. As a unit within the Department of Health, and now established as the Department of Mental Retardation, the state agency has emphasized use of a small central staff with primary program responsibility decentralized to 12 regions. The regional staff is responsible for two things: (1) the provision of direct services through residential, day training, diagnosis, referral, emergency services, and follow-up programs; and (2) serving as a catalyst to the community for the development of service alternatives through private or other resources.

Populations in the state institutions have decreased substantially. Mansfield Training School is down from a 1968 high of 1,900 to a current population of 1,100. The Southbury facility is down from 2,050 in 1968 to 1,500 at present.

What began in 1964 with three group homes is now a network of 28 state-operated group homes and an additional 20 homes privately operated. The current budget request includes 33 additional group homes.

In addition, state monies are made available to contract with private and other public resources to provide services. Some previously institutionalized persons who lived in group homes for a while now live semi-independently in sections of apartment complexes leased by the state agency with follow-up services provided by the regional staff. Over 300 elderly, mildly retarded persons are placed in private boarding homes.

The decentralized regional staff appears to be a key to Connecticut's success. The regions are responsible to see that services are provided near the individual's home and that services are accessible to him. Additionally, the regional staff is charged with ensuring that the individual has access to all available services, not just those provided by the department.

The Legislature has continued to support deinstitutionalization,

enabling the department to create additional regional centers with funding for necessary community alternatives.

A Virginia Experience

One theme running through much of the discussion of deinstitutionalization is the need to provide individuals discharged from institutions with a wide range of community resources.

The Services Integration for Deinstitutionalization (SID) project in Virginia is an example of an attempt to address this issue. SID began in 1974 in two demonstration areas—Planning District Number 6, a rural area, and the city of Portsmouth, an urban area. An Assessment and Prescription team is composed of representatives of the various service providers (public and private) in the area. This team meets regularly to review cases of individuals being discharged from various institutions who will be returned to a particular community. SID staff members serve as staff to the Assessment and Prescription team. The team attempts to design a service program utilizing various agency services to facilitate the individual's return to the community.

Originally the project was administered through the Department of Mental Health and Mental Retardation, with 11 other state agencies participating, and funded largely through a federal grant. On July 1, 1976, when federal and state money was no longer available, the city of Portsmouth took over sponsorship of the project. The city contributed 25 percent of the program's $200,000 budget, to be matched with 75 percent through Title XX of the Social Security Act.

The project employs eight SID staff members and serves about 400 individuals. These include the mentally retarded, mentally ill, and juvenile offenders. In addition to patients being released from state institutions, SID seeks out those in need of multiple services who currently live in the community in an attempt to prevent their institutionalization.

Conclusion

For state administrative officials and legislators, the movement to establish certain basic rights of the mentally disabled has not gone unnoticed. State Legislatures have begun to enact legislation detailing procedures whereby patients may be committed and treated involuntarily. They are still wrestling with the issue of how to set standards for minimum treatment levels and to monitor these standards periodically. Legislators have heard complaints from parents of retarded children and hospital employees when hospitals are closed or rumored to be closed.

Legislators and budget staff charged with appropriations responsibilities are faced with several difficult decisions. In States where court decisions have required minimum standards for treatment, courts have in fact made decisions about the appropriation of state funds. Increased concern for the plight of the mentally ill has prompted large expenditures for refurbishing of state institutions. At the same time that facilities are being remodeled, there is pressure to redirect these resources to establishing a variety of community programs. The expenditure of large sums of money on facilities creates pressure to maintain programs in these facilities. Likewise, the introduction of community alternatives to institutions tends to create opposite pressures.

Program planners are faced with designing community programs emphasizing placement of individuals in programs least restrictive of personal freedoms, early identification of handicaps, prevention of unnecessary institutionalization, and follow-up for patients discharged from institutions.

Public officials, sensitive to community attitudes and equally aware of the impact of court decisions, may be uneasy over the conflict that the prevailing attitudes and decisions engender. Nevertheless, the pendulum appears to continue to swing in the direction of a greater awareness of the rights of the mentally disabled.

Footnotes

1. Morton Birnbaum, "The Right to Treatment," *American Bar Association Journal*, vol. 46, 1960, p. 499.

2. *Rouse* v. *Cameron*, 373 F. 2d 451 (D.C. Cir. 1966).

3. *John W. Nason* v. *Superintendent of Bridgewater State Hospital*, 363 Mass. 604, 233 N.E. 2d 908 (1968).

4. *Wyatt* v. *Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972).

5. *Shelton* v. *Tucker*, 364 U.S. 479, 488 (1960).

6. *Lake* v. *Cameron*, 364 F. 2d 657 (D.C. Cir. 1966).

7. *Lessard* v. *Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), remanded for clarification, 414 U.S. 473 (1974).

8. David L. Chambers, "Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives," 70 *Michigan Law Review* 1108 (1972).

9. Public Law 94-103, 42 U.S.C.S. 600.

10. *Brown* v. *Board of Education*, 347 U.S. 483, 74 S. Ct. 686 (1954).

11. *Pennsylvania Association for Retarded Children* v. *Commonwealth of Pennsylvania*, 334 F. Supp. 1257 (E.D. Pa. 1971).

12. Public Law 94-142, 20 U.S.C.S. 1401.

13. "Developments in the Law: Civil Commitment of the Mentally Ill," *Harvard Law Review*, vol. 87, 1973-74, p. 1,266.

14. *Lynch* v. *Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974).

15. Bruce Ennis and Loren Siegal, *The Rights of Mental Patients* (New York, N.Y.: Richard W. Baron, 1973), p. 21.

16. *O'Connor* v. *Donaldson*, 422 U.S. 563, 95 S. Ct. 2486 (1975).

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Appendix 1

Three statutes are presented as examples of the responses of State Legislatures to the demand for greater attention to the rights of the mentally disabled.

1. The Michigan statute comprehensively addresses state responsibilities to the mentally ill and the mentally retarded.

2. The Florida statute spells out a list of rights guaranteed to residents of state institutions for the retarded.

3. The Ohio statute addresses state commitment procedures for the mentally ill and the rights of hospitalized patients.

Michigan Mental Health Code, Public Act 258 (1974)

Michigan has adopted a single statute covering all laws dealing with mental illness and mental retardation.

Chapter 1 relates to the organization of the State Department of Mental Health, including the powers and duties of the department.

Chapter 2 revises those statutes pertaining to community mental health programs, including their relationships to local governments.

Chapter 3 establishes new and uniform procedures and responsibilities for state and county financing of state institutions and community mental health programs in an attempt to minimize financial incentives in the choice of where services are to be given.

Chapter 4 prescribes comprehensive standards and procedures to govern the voluntary and involuntary admission and discharge of mentally ill individuals in both public and private hospitals.

Chapter 5 sets out admission and discharge procedures for the mentally retarded. The statute minimizes the likelihood of involuntary judicial admission to a state facility. It also establishes comprehensive administrative procedures for voluntary admissions.

Chapter 6 addresses guardianship procedures for determining the need for a guardian, appointment of a temporary—or partial—guardian, and the duties and responsibilities of the guardian.

Chapter 7 deals with the rights of persons receiving mental health services. It provides that a resident of a public mental health facility is entitled to treatment suited to his condition, a humane living environment, periodic examinations, an individualized written plan of services, and regular information about his clinical status and progress. This chapter includes procedures for protection of patient rights involving surgery, electro-convulsive therapy, patient abuse, privacy, financial holdings, required labor, physical restraints, patient records, and communications. The department is required every two years to report to the Governor and the Legislature evaluating public mental health facilities in terms of the extent to which they meet established legal standards for quality of care.

Chapter 8 relates to the procedures for determining the financial liability of patients and their families.

Chapter 9 contains several miscellaneous provisions, including procedures for placing individuals in facilities in other States and receiving patients from other States into Michigan facilities.

Chapter 10 relates to patients receiving mental health services information who are involved in criminal justice procedures as well. This includes procedures for determining that individuals charged with a crime are incompetent to stand trial. The statute also provides for the transfer of individuals between mental health facilities and criminal justice facilities and the accompanying responsibilities of state agencies.

Florida Bill of Rights for Retarded Persons, Chapter 393.13 (1975)

Definitions — "Habilitation" means the process by which an individual is assisted to acquire and maintain those life skills which enable him to cope more effectively with the demands of his own person and his environment and to raise the level of his physical, mental, and social efficiency. "Normalization principle" means the principle of letting the mentally retarded obtain an existence as close to the normal as possible, making available to them patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society.

Legislative Intent — It is specifically recorded and includes:

(1) That the system of care provided to mentally retarded individuals be designed to meet the needs of clients as well as protect the integrity of their legal and human rights.

(2) That the design and delivery of services to the retarded be directed by the principles of normalization and therefore should abate the use of large institutions and continue the development of community-based services in settings least restrictive to the client.

(3) That the existing legal and human rights of the retarded be articulated so they may be exercised and protected.

(4) That these individuals be diverted from institutional commitment who, by virtue of professional diagnosis and evaluation, can be placed in less costly, more effective, community environments and programs.

(5) That a plan be developed for the most efficient and effective delivery of services to the retarded while safeguarding their rights.

Client Rights — They include, in varying degrees of specificity, the right to:

(1) Dignity, privacy, and humane care.

(2) Religious freedom and practice.

(3) Unrestricted communication, including receiving, sending, and mailing sealed, unopened correspondence; reasonable opportunity for phone calls; and an unrestricted right to visitation.

(4) Possession and use of his own clothing and personal effects.

(5) Receive education and training services regardless of chronological age, degree of retardation, or accompanying disabilities or handicaps.

(6) Receive prompt and appropriate medical treatment and care for physical and mental ailments and the prevention of any illness. Administration of medication requires recordkeeping and periodic review and medical treatment consistent with accepted standards.

(7) Suitable opportunities for behavioral and leisure time activities which include social interaction.

(8) Appropriate physical exercise as prescribed in the client's individual habilitation plan.

(9) Receive humane discipline.

(10) Physical examination prior to subjection to a treatment program to eliminate bizarre or unusual behaviors.

(11) Minimum wage protection and fair compensation for labor.

(12) Be free from physical restraint. Procedures for restraints which impose the least possible restrictions consistent with their purpose (protect client or others from injury) are spelled out.

(13) A central record, which includes procedures for entry, maintenance, and examination of such record.

Ohio Mental Health Commitment Law, Substitute House Bill No. 244

Definitions — "Mentally ill" means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

Procedures for Involuntary Commitment — To be hospitalized the individual must (1) have evidenced that he is a substantial risk of physical harm to himself, (2) have evidenced that he is a threat to physical well-being of others, (3) have shown an inability to provide for his own physical needs, or (4) would benefit from treatment and is in need of treatment as evidenced by behavior that shows his or others' rights to be at risk. A full hearing with client represented by counsel is required within 45 days. All documentation and evidence must be made available to the client. If committed, the individual must be released after 90 days unless formal application is filed with the court.

Emergency Commitment — An individual may be taken into custody by specified professionals for a period of three days. A written statement explaining the circumstances of the detention, availability of counsel, and an independent evaluation of his mental condition is required. Individual is further entitled to a probable cause hearing and procedures for such a hearing are prescribed.

Least Restrictive Alternative — The court is required to consider the diagnosis, prognosis, and projected treatment plan in ordering the client's placement in the least restrictive alternative available and consistent with treatment goals.

Rights of Hospitalized Persons — The individual will receive an evaluation and prognosis, a written treatment plan consistent with the evaluation, treatment consistent with the plan, periodic reevaluation of the plan, and adequate medical treatment. Further, the individual will receive humane care and treatment, including:

(1) The least restrictive environment consistent with the treatment plan.

(2) Necessary facilities and personnel required by the plan.

(3) A humane psychological and physical environment.

(4) The right to current information concerning his treatment program.

(5) Participation in programs designed to afford him substantial opportunity to acquire needed skills.

(6) The right to be free from unnecessary or excessive medication.

(7) Freedom from restraints or isolation under most conditions.

Should the facility not be able to assure the above, procedures for notification of patient, family, counsel, and Legal Rights Service are provided.

Patient must receive information to provide for his fully informed, intelligent, and knowing consent to (1) surgery, (2) convulsive therapy, (3) programs involving aversive stimulae, (4) sterilization, and (5) any unusually hazardous treatment procedures or psycho-surgery.

Other rights guaranteed to the patient include the right to be treated with respect and dignity; to be protected from assault; to communicate and be visited freely by friends or counsel; to personal privileges such as wearing one's own clothing, keeping personal possessions, and having privacy and private space; to exercise religious preferences; and to interact with members of either sex, subject to supervision.

Ohio Legal Rights Service — Previously in existence to provide representation to clients detained under the mental retardation statutes, it is expanded to include services to persons institutionalized as mentally ill. The service is independent of the State Attorney General and the Mental Health/Mental Retardation Agency.

Appendix 2

Selected Associatons and Organizations in the Field of Mental Disability

American Association on Mental Deficiency
5201 Connecticut Avenue, N.W.
Washington, D.C. 20015
(202) 686-5400

American Coalition of Citizens with Disabilities
1346 Connecticut Avenue
Washington, D.C. 20036
(202) 785-4265

American Hospital Association
840 N. Lake Shore Drive
Chicago, Illinois 60611
(312) 645-9400

American Physical Therapy Association
1156 15th Street, N.W.
Washington, D.C. 20005
(202) 466-2070

American Psychiatric Association
1700 18th Street, N.W.
Washington, D.C. 20009
(202) 232-7878

American Public Welfare Association
1155 16th Street, N.W.
Washington, D.C. 20036
(202) 833-9250

American Speech & Hearing Association
9030 Old Georgetown Road
Washington, D.C. 20014
(202) 530-3400

Association for Children with Learning Disabilities
5225 Grace Street
Pittsburgh, Pennsylvania 15236
(412) 881-1191

Bureau of Education for the Handicapped, U.S. Office of Education
ROB #3, Room 2100
7th & D Streets, S.W.
Washington, D.C. 20202
(202) 245-9661

Child Welfare League of America
67 Irving Place
New York, New York 10003
(212) 254-7410

Council for Exceptional Children
1920 Association Drive
Reston, Virginia 22091
(703) 620-3660

Council of State Administrators of Vocational Rehabilitation
Suite 610, 1522 K Street, N.W.
Washington, D.C. 20005
(202) 638-4634

Developmental Disabilities Office, Office of Human Development, Dept. of Health, Education, and Welfare
330 C Street, S.W.
Washington, D.C. 20201
(202) 245-0870

Epilepsy Foundation of America
1828 L Street, N.W.
Washington, D.C. 20036
(202) 293-2930

Human Resources Center
U.U. Willets Road
Albertson, New York 11507
(516) 747-5400

International Association of Rehabilitation Facilities, Inc.
No. 955, 5530 Wisconsin Avenue
Washington, D.C. 20015
(202) 654-5882

Muscular Dystrophy Associations of America, Inc.
810 Seventh Avenue
New York, New York 10019
(212) 586-0808

National Association for Hearing and Speech Action
814 Thayer Avenue
Silver Spring, Maryland 20910
(301) 588-5242

The National Association for Mental Health, Inc.
1800 North Kent Street
Arlington, Virginia 22209
(703) 528-6405

National Association for Retarded Citizens
P.O. Box 6109, 2709 Avenue E East
Arlington, Texas 76011
(817) 261-4961

National Association of Coordinators of State Programs for the Mentally Retarded
Suite 802, 2001 Jefferson Davis Highway
Arlington, Virginia 22202
(703) 920-0700

National Association of the Deaf
814 Thayer Avenue
Silver Spring, Maryland 20910
(301) 587-1788

National Association of Private Psychiatric Hospitals
Suite 1205, 1701 K Street
Washington, D.C. 20006
(202) 223-6691

National Association of State Mental Health Program Directors
1001 3rd Street, S.W.
Washington, D.C. 20024
(202) 554-7807

National Center for a Barrier-Free Environment
Suite 402, 8401 Connecticut Avenue
Washington, D.C. 20015
(202) 656-9496

National Conference on Developmental Disabilities
Suite 400, Travelers Building
1108 E. Main Street
Richmond, Virginia 23219
(804) 786-7787

National Easter Seal Society for Crippled Children and Adults
2023 West Ogden Avenue
Chicago, Illinois 60612
(312) 243-8400

National Federation of the Blind
Suite 212, 1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 785-2974

National Multiple Sclerosis Society
205 E. 42nd Street
New York, New York, 10017
(212) 532-3060

National Paraplegia Foundation
333 N. Michigan Avenue
Chicago, Illinois 60601
(312) 346-4779

National Rehabilitation Association
1522 K Street, N.W.
Washington, D.C. 20005
(202) 659-2430

National Society for Autistic Children
169 Tampa Avenue
Albany, New York 12208
(518) 489-7375

President's Committee on Mental Retardation
7th and D Streets, S.W.
Washington, D.C. 20201
(202) 245-7634

Public Citizen Inc.
Health Research Group
2000 P Street, N.W.
Washington, D.C. 20036
(202) 872-0320

Rehabilitation Services Administration
Room 3006, Switzer Building
330 C Street, S.W.
Washington, D.C. 20201
(202) 245-8492

United Cerebral Palsy Association, Inc.
3rd Floor, 66 E. 34th Street
New York, New York, 10016
(212) 889-6655